surgery as for their non-pregnant counterparts, although if they are in the second half of pregnancy they should be nursed in the left lateral position to prevent supine hypotension caused by the weight of the pregnant uterus on the inferior vena cava.

The fetus should be monitored by cardiotocography, probably for four hours. Abnormalities of the fetal heart rate usually permit early diagnosis of a placental abruption, which in many cases is not accompanied by vaginal bleeding. In the acute phase ultrasonographic examination will not usually be helpful until the abruption is clinically obvious, but mothers find ultrasonography reassuring. Delayed abruption may occur four to five days after the accident, which suggests that patients should probably be kept in hospital for five days.

Other effects on the pregnancy may be preterm labour, premature rupture of the membranes, and fetomaternal haemorrhage. Haemorrhage should be sought with a Kleihauer test, and if the patient is rhesus negative anti-D gammaglobulin should be given. Any fetal anaemia resulting from fetomaternal haemorrhage is rarely severe enough to threaten the fetus. Pelvic fractures in pregnancy may be associated with substantial retroperitoneal bleeding, causing hypovolaemic shock, or injuries to the urinary tract or uterus. In the absence of severe deformity delivery through a recently fractured pelvis is not usually accompanied by serious complications. There is little or no evidence on the effect of seat belts on the occurrence of these complications.

Strong evidence therefore exists to support the use of seat belts in pregnancy; they should be worn over and under the bump. There is also evidence that health care professionals do not routinely educate pregnant women in the correct use of seat belts and that some carers give dangerous advice. Finally, there is evidence that when pregnant women receive advice from trained instructors they are more likely to wear seat belts.14

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have increased sharply in recent years, particularly since compulsory restrictions on the size of families were introduced in some parts of the country in the late 1970s. There are also some new, ominous signs in China, such as a substantial increase in the reported ratio of male to female births—quite out of line with the rest of the world. It could quite possibly indicate “hiding” of newborn female children (to avoid the rigours of compulsory restriction on the size of the family), but it could, no less plausibly, reflect a higher female infant mortality—whether or not induced (with new births and new deaths both going unreported).

What causes the relative neglect of females, and how can it be changed? Possible influences include traditional cultures and values. But some economic links have also emerged, and some connections between economic status and social standing have been identified. For example, the ability to earn an outside income through paid employment seems to enhance the social standing of a woman (which is the case in sub-Saharan Africa). This makes her contribution to the prosperity of the family more visible. Also, being less dependent on others, she has more voice. The higher status of women also affects ideas on the female child’s “due.” Secondly, education, especially female literacy, may make a substantial difference. Thirdly, women’s economic rights (for example, land ownership and inheritance) may be important. Public policy can influence all of these.

The Indian state of Kerala provides an illuminating exception to the prevailing experience. It has the most developed school education system in India, which dates from the early nineteenth century, with strongly supportive state policies in the “native kingdoms” of Travancore and Cochin. Adult literacy rate is now over 90%. Property inheritance passes through the female line for an influential part of the community (the Nairs). Many women participate in “gainful” economic activities. Kerala also has an extensive health care system, which has been built up through public policy. Even though Kerala is one of the poorer Indian states, life expectancy at birth there now exceeds 73 years for women and 67 years for men.

The female: male ratio of the Kerala population is now around 1:04—similar to that in Europe and America (and most unlike that in the rest of India, Bangladesh, Pakistan, China, west Asia, and north Africa). It seems that the “missing women” may be rescuable, after all, by public policy.

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On your bikes

Doctors should be setting an example

Urban cyclists are a heroic and selfless breed: they would rather brave congestion and smog than add to them. Seen by motorists as pests, they have been in decline since the 1950s. But this week, with the publication of the BMA’s report on cycling, they and their environment have found a new and important champion.1

The health benefits of cycling are well documented. Regular physical exercise delays postmenopausal osteoporosis and lowers cardiac morbidity and mortality—perhaps by reducing body fat and blood pressure and increasing the ratio of high density to low density lipoproteins. It may also improve mental health and all cause mortality.2 As a form of aerobic exercise cycling is ideal; it makes use of the large limb muscles without putting strain on the joints. The energy requirements of cycling 6-5 km each way to work at a speed of about 20 km/h are equivalent to those of 10 minutes’ wrestling, over half an hour’s squash, 50 minutes’ tennis singles, an hour’s skating, a brisk 4 km walk, or 24 holes of golf.3 Studies have shown that civil servants who cycled regularly experienced half the expected number of coronary events,4 and lifelong cyclists over the age of 75 had a 10-fold reduction in the incidence of ischaemic heart disease.5

But being cardiovascularly and mentally fit is of little use if you are knocked off your bicycle by the next car turning left. For cycling to be truly beneficial to cyclists instead of just to their fellow urbanites it also has to be safe. This cycling is patently not, and the danger has increased over the past 40 years. Between 1952 and 1987 deaths per billion kilometres travelled by cycle in Britain almost doubled.6 Added to the risk of injury is the fear of injury, with the result that, according to the London Cycling Campaign, one million people who would like to cycle in the capital have been deterred. Traffic fumes, noise, and congestion are also to blame.

Cycling is now taking on all the signs of an unsafe activity. The carefree, hair free child in the butter commercial has become a fully armoured vehicle sporting helmet, reflective clothing, and face mask. These are valid forms of protection and are endorsed by the BMA, with the caveat that the main thing in their favour may be that they draw attention to the problems of road safety and air pollution. But they have no effect on the cause of the problems. They hamper the cyclist while leaving the motorist, the source of the danger and the dirt, unrestrained.

Almost everyone can cycle—99% of men and 87% of women in a 1989 Mintel survey—but progressively fewer do. Annual sales of bicycles in Britain are equivalent to car sales, but while 94% of cars are used every day only one in four bicycles is used in a typical week.7 In the 1950s 10% of all travel by mechanical means was by bicycle, mostly for commuting to work. Now the figure is 1%, mostly for leisure.8 And as more people take to their cars to avoid the increasingly hostile urban environment a vicious cycle develops. More cars mean more fumes and accidents, which deters more people from cycling, which means more cars. Town planners fuel the upward spiral, building motorways...